

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

10106

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

No. St. Johns Hospo

File No.....

Registered No.....

2687

St.

Ward)

2. FULL NAME

(a) Residence. No.
(Usual place of abode)

St.

12 Ward.

Locksburg Ark.

(If nonresident give city & town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Lora Dobbins

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

June 22 1901

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. min.

25

8

26 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

City Sanitarian

(b) General nature of industry, business, or establishment in which employed (or employer)

Attendant

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ark.

10. NAME OF FATHER

Jos. Dobbins

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

North Carolina

12. MAIDEN NAME OF MOTHER

Allie Webber

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tenn.

14.

INFORMANT

(Address)

Mrs. L. R. Dobbins
Locksburg Ark.

15.

FILED

18 1927
Wm B. Starckoff

REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

March 18 1927

17.

HEREBY CERTIFY That I attended deceased from Mar 3 1927, to Mar 18 1927 that I last saw him alive on Mar 18 1927, and that death occurred, on the date stated above, at 10 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uremia
Chr Nephritis
131 / 29 A
135 / 29 A
135 / 29 A (duration) yrs. mos. 21 ds.
CONTRIBUTORY Acute nephritis
(SECONDARY)
(duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

Unknown

19. DID AN OPERATION PRECEDE DEATH?

No. DATE OF X

20. WAS THERE AN AUTOPSY?

No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

Laboratory
Grayson Carroll M.D.

Mar 18, 1927 (Address)

570 Century Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Locksburg Ark

Mar 18 1927

20. UNDERTAKER

ADDRESS

Mullen and Co.

5165

Delmar Bl.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

